

5124

CERTIFICATE OF DEATH

05095  
Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. <del>EDITOR TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#2</b>				c. LENGTH OF STAY IN 1b <b>71 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Urbana</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BION</b> Middle <b>EUGENE</b> Last <b>ANDERSON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Nov 1881</b>	9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas A. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Emma S. Bopst</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-4285</b>		17. INFORMANT Address <b>Mrs. Mary B. Anderson (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerosis</b> <b>42.1.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 yrs. +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10, 1955</b> to <b>May 22, 1956</b> , that I last saw the deceased alive on <b>May 21, 1956</b> , and that death occurred at <b>5:15 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. O. Thomas</b>		ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b>					
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		DATE SIGNED <b>5/22/56</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 23 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE FILLED BY THE REGISTRAR OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4  
to be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5101

## CERTIFICATE OF DEATH

05096

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 Frederick Memorial Hospital			d. STREET ADDRESS Route 6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Robert Wayne S. Aylor			4. DATE OF DEATH Month Day Year May 5 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10-1955	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William A. Aylor			14. MOTHER'S MAIDEN NAME Mildred Lacey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. A. Aylor-Route 6- Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis DUE TO (c) Perforated Appendix PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 WK 4 WK 4 1/2 WK
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 April, 1956, to 5 May, 1956, that I last saw the deceased alive on 5 May, 1956, and that death occurred at 12:05 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. A.M. Powell Jr. 220 N. Market St.-Frederick-Md. 7 May 56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son - Frederick-Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7 May 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

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BUREAU V. S.

MAY 9 1956

RECEIVED

5125

## CERTIFICATE OF DEATH

Reg. Dist. No.

05097

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Walkersville</u>				c. <del>CITY OR TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Walkersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>BURRIER</u> Last <u>BURRIER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1874</u>	9. AGE (In years, lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Albert Eares</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Clara Titman, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Bronchial pneumonia</u> DUE TO (b) <u>arteriosclerotic CVD</u> DUE TO (c) <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1 NOV</u> , 19 <u>55</u> , to <u>19 MAY</u> , 19 <u>56</u> that I last saw the deceased alive on <u>19 MAY</u> , 19 <u>56</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>21 May '56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Md. Liberty town Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 22 May 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

131

BUREAU V. S.

MAY 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05098

Reg. Dist. No. 131

Item 20 Film GL98 6-8-56

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#2</b>		c. LENGTH OF STAY IN 1b <b>4 Months</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Grove Road</b>						d. STREET ADDRESS <b>Grove Road</b>					
3. NAME OF DECEASED (Type or print) First <b>LINDA</b> Middle <b>CLARISSA</b> Last <b>COLLINS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 56</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 Dec 1955</b>		9. AGE (In years last birthday) yrs. <b>5</b> Months <b>9</b> Days <b></b> Hours <b></b> Min. <b></b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Buster R. Collins</b>				14. MOTHER'S MAIDEN NAME <b>Nellie May Sexton</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Buster R. Collins</b>		Address <b>(Same as item #2)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Strangulation (accidental)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby lying on abdomen, head caught between pillow &amp; head of bed.</b>							
20c. TIME OF INJURY Hour <b>5</b> a. m. <b></b> p. m. <b></b> Month, Day, Year <b>May 23 19 56</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (farm)</b>		20f. (City or town) <b>Frederick RD #2,</b>		(County) <b></b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<b>24 May 1956</b>			
22a. <del>DATE OF CREMATION</del> REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>24 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) <b>Jonesville, Virginia</b>		(State) <b></b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						24a. REC'D BY REGISTRAR DATE <b>24 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Herb</b>			

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2269213404

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		MAY 1 1968		MEMPHIS, TENN.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		ATTORNEY		HIGH SCHOOL		MARRIED		HEART DISEASE		NATURAL	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
MAY 1 1933		MEMPHIS, TENN.		MAY 1 1955		MAY 1 1955		MAY 1 1955		MAY 1 1955	
DATE OF DEATH		PLACE OF DEATH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
MAY 1 1968		MEMPHIS, TENN.		MAY 1 1955		MAY 1 1955		MAY 1 1955		MAY 1 1955	
DATE OF DEATH		PLACE OF DEATH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
MAY 1 1968		MEMPHIS, TENN.		MAY 1 1955		MAY 1 1955		MAY 1 1955		MAY 1 1955	

BUREAU V. S.

MAY 28 1968

RECEIVED



5102

## CERTIFICATE OF DEATH

Reg. Dist. No.

05099  
131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>1770</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>				d. STREET ADDRESS <u>Route #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>E.</u> Last <u>Conaway</u>				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/24/1877</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>30</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>30</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter -retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Reuben Conaway</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Brice Conaway, Woodbine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of Brain</u> DUE TO <u>Thrombosis of cerebral artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Anteriodorsal, generalized</u> DUE TO <u>Anteriodorsal, generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1770.</u> <u>1770.</u> <u>104 yrs +</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/5</u> , 19 <u>56</u> , to <u>5/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E Church St</u> DATE SIGNED <u>5/30/56</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-2-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church Of God</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>2 June 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
ALBANY, N.Y.  
JANUARY 10, 1967  
TO THE HONORABLE  
GOVERNOR AND COMPTROLLER  
OF THE CURRENCY  
FROM  
THE STATE DEPARTMENT OF HEALTH  
SUBJECT:  
REPORT ON THE PROGRESS OF THE  
STATE DEPARTMENT OF HEALTH  
DURING THE YEAR 1966

181

BUREAU V. 3

1956 5 1111

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05100  
131

5103

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Hour</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>315 East Patrick Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MATILDA</b> Last <b>Crum</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1895</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles A. Fogle</b>				14. MOTHER'S MAIDEN NAME <b>Ida White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-03-1448</b>		17. INFORMANT Address <b>Mrs. Hannah M. Keeney, 14 Frederick Avenue, Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>54 years</b> DUE TO <b>(with Pulmonary oedema).</b> <b>(12 hours)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma breast, right</b> <b>1 1/2 year</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 1</b> , 1955, to <b>May 29</b> , 1956, that I last saw the deceased alive on <b>May 29</b> , 1956, and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b> M.D. <b>Frederick, Md</b> <b>May 29, 1956</b> PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas Jr.</b> <b>Frederick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>31 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heick</b>	

MEDICAL CERTIFICATION

TO HEALTH OFFICER: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5104

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 South Market Street</b>				d. STREET ADDRESS <b>24 South Market Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CECILIA</b> Middle <b>MARION</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1875</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Mrs. Edna F. McClellen - 24 S. Market Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b> <b>20 yrs.</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1935</b> to <b>May 12, 1956</b> , that I last saw the deceased alive on <b>May 12, 1956</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 N. Market Street - Frederick, Maryland</b> DATE SIGNED <b>Frederick Md</b>							
ACTUAL SIGNATURE <b>A. F. Kline</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Chinn &amp; Son</b>				ADDRESS <b>Frederick Md</b>		24a. REC'D BY REGISTRAR <b>DATE 14 May 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

2102

121

BUREAU V. S.

MAY 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5105 CERTIFICATE OF DEATH

05102

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg Route #1 151-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>69 Frederick Memorial Hosp</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lloyd</u> Middle <u>L</u> Last <u>Day</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>6</u> Year <u>1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>4/7/1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>Joseph Day</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza Gibbs</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>## Unknown</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 yrs. +</u>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> (County) (State) _____							
<b>21. I certify that I attended the deceased from</b> <u>5/4</u> , 19 <u>56</u> , to <u>5/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>56</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>4 E. Church St. Frederick 5/6/56</u> PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 9 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rocky Hill</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Clarksburg Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>9 May 1956</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Elizabeth B. Hech</u>				<b>24c. REGISTRAR'S SIGNATURE</b> <u>Ray W. Barber</u>			
<b>24d. REGISTRAR'S SIGNATURE</b> <u>Laytonville, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
Joseph Day		Male		35		1910		Maryland		Accident		Falls from a building		City of Baltimore		1950		J. H. [Signature]		[Signature]	
Occupation		Employer		Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of [Other]	
Labor		Day Work		1950		10:00 AM		City of Baltimore		Falls from a building		City of Baltimore		1950		J. H. [Signature]		[Signature]		[Signature]	
Married		Single		1910		1910		Maryland		Accident		Falls from a building		City of Baltimore		1950		J. H. [Signature]		[Signature]	
U.S.A.		U.S.A.		1910		1910		Maryland		Accident		Falls from a building		City of Baltimore		1950		J. H. [Signature]		[Signature]	

BUREAU V. S.

MAY 10 1956

RECEIVED

May 9 1956 ROOKY HILL  
Baltimore, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5127

## CERTIFICATE OF DEATH

Reg. Dist. No.

05103

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Md. Rural</b>				c. LENGTH OF STAY IN 1b <b>25 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Thurmont, Md. Rt. #2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Pierce</b> Last <b>DeBerry</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1889</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>26</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rubber Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Blue Ridge Rubber</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John William DeBerry</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Martin DeBerry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-18-0683</b>			
17. INFORMANT <b>Vallie I. DeBerry</b>				Address <b>Thurmont, Md. RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningioma, left fronto-parietal area</b> <b>223X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 4, 1956</b> , to <b>May 7, 1956</b> , that I last saw the deceased alive on <b>May 7, 1956</b> , and that death occurred at <b>8:40 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b>				DATE SIGNED <b>5/8/56</b>			
ACTUAL SIGNATURE <b>M. Franklin Birely</b>				M.D. <b>Thurmont, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Mr. M. Franklin Birely</b>				<b>Thurmont, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Treagus</b>				ADDRESS <b>Thurmont, Md.</b>			
24a. REC'D BY REGISTRAR <b>DATE</b>				24b. REGISTRAR'S SIGNATURE <b>d. H. Hedrick</b>			

TO HO... ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Frank		Male		25 yrs.		Nov. 11, 1930		Chicago, Ill.	
Cause of Death		Occupation		Date of Death		Place of Death		Physician	
Rubber work		Rubber work		Nov. 11, 1956		Chicago, Ill.		J. J. [illegible]	
Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of [illegible]	
Natural		[illegible]		[illegible]		[illegible]		[illegible]	

BUREAU V. 3

MAY 9 1956

RECEIVED

Dr. J. J. [illegible]  
[illegible]  
[illegible]



5106

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11 Frederick</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>69 FREDERICK MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>819 East Potomac</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Hodges</b> Last <b>Dillow</b>				4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15 1906</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building roads</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Dillow</b>				14. MOTHER'S MAIDEN NAME <b>Martha Cage</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-09-7661</b>			
17. INFORMANT <b>Mrs. Bessie Forrest</b>				Address <b>Brunswick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right lung with metastases to brain, ribs and lumbar spine.</b> DUE TO (b) <b>lumbar spine.</b> DUE TO (c) <b>lumbar spine.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8</b> , 1956, to <b>May 11</b> , 1956, that I last saw the deceased alive on <b>May 10</b> , 1956, and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 East Church St. Frederick Md.</b> DATE SIGNED <b>5-12-56</b> ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>ROBERT S. TURNER, JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5-13-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fitch</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR <b>May 16</b> 24b. REGISTRAR'S SIGNATURE <b>Clay A. Beck</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MINISTER	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY		19. SIGNATURE OF JUDGE		20. SIGNATURE OF CLERK	

BUREAU V. S.

MAY 15 1956

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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05105

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont-Rural-R.D.#1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>226 East Patrick Street</b>			d. STREET ADDRESS <b>Near Thurmont</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NEWTON</b> Middle <b>EDWARD</b> Last <b>EILER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 16, 1895</b>		9. AGE (In years last birthday) <b>60 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Owen Eiler</b>		
14. MOTHER'S MAIDEN NAME <b>Nettie Six</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <input checked="" type="checkbox"/> <b>WWI</b>		
16. SOCIAL SECURITY NO. <b>217-10-9688</b>			17. INFORMANT <b>Mrs. Alice G. Eiler, RD#1, Thurmont, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Posterior Myocardial Infarct</b> <b>420.1</b> DUE TO <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b> <b>2 Yrs plus</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>B. O. Thomas</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>8 May 1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			ADDRESS		
24a. REC'D BY REGISTRAR <b>9 May 1956</b>			24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>		

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	

5128

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Walkersville</u>				c. LENGTH OF STAY IN 1b <u>33 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>Rural, Walkersville</u>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRAYSON EYLER</u>				4. DATE OF DEATH Month Day Year <u>May 2 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1875</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Eyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Dieterman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Annie Eyer, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of jaw</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis into brain</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>53</u> , to <u>May 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>56</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Frederick, Md May 4-56</u>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Frederick, Md May 4-56</u>					
PHYSICIAN'S NAME (Type) <u>DR. B. O. THOMAS, SR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5 May 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hecks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

181

BUREAU Y. S.

MAY 7 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5108 CERTIFICATE OF DEATH

05197  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Pines Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Orpha</b> Middle <b>Olivia</b> Last <b>FISHER</b>		4. DATE OF DEATH Month <b>May.</b> Day <b>21.</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26. 1868</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wilhide</b>		14. MOTHER'S MAIDEN NAME <b>Susan Blessing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Newton I. Fisher</b>		Address <b>Thurmont MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, Pyelitis + cystitis, chronic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 18, 1956</b> , to <b>May 18, 1956</b> , that I last saw the deceased alive on <b>May 18, 1956</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>7 E. Church St. Frederick</b> DATE SIGNED <b>5-21-56</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT S. TURNER, JR.</b>		<b>MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23. 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont Frederick Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Cragg</b>		ADDRESS <b>Thurmont</b>	
24a. REC'D BY REGISTRAR <b>DATE 23 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	

CERTIFICATE OF DEATH

131

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JOHN WILLIAMS		MALE		45		JAN 15 1885		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		2 weeks		MAY 10 1936		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERVIEWER	
DR. J. H. BROWN		St. Paul's Hospital		Miss J. H. BROWN		Rev. J. H. BROWN		St. Paul's Church		St. Paul's Funeral Home		St. Paul's Cemetery		J. H. BROWN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF INTERVIEWER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAY 24 1936

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5109

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Julia Fogle</u>				4. DATE OF DEATH <u>May 24 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14-1882</u>	
9. AGE (In years, last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Noonan</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Riordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Norman Fogle, Alney, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> 19 <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17</u> , 19 <u>56</u> , to <u>May 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>56</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. A. Gane</u>				ADDRESS (Street, city or town, state) <u>Frederick, Md</u>		DATE SIGNED <u>5/24/56</u>	
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Libertytown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler &amp; Sons</u>				ADDRESS <u>Libertytown, Md</u>		24a. REC'D BY REGISTRAR <u>Elizabeth S. Heck</u>	
						24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

151

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH	
LABORER		8		M		C		HEART DISEASE		2 WEEKS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MAY 31 1956		10:00 AM		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

MAY 31 1956

RECEIVED

James H. Harris



5129

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3</b>				d. STREET ADDRESS <b>R.D.#3</b>			
3. NAME OF DECEASED (Type or print) <b>William Albert Frailey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1892</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>druggist</b>		11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Oscar D. Frailey</b>				14. MOTHER'S MAIDEN NAME <b>Clara M. Hoke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 141-05-4861</b>		17. INFORMANT <b>Wm. A. Frailey</b> Address <b>Emmitsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiac vas disease</b> DUE TO (c) <b>Spasms</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22, 1956</b> , to <b>May 28, 1956</b> , that I last saw the deceased alive on <b>May 28, 1956</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. A. Cade</b>		M.D. <b>Emmitsburg, Md.</b>		ADDRESS (Street, city or town, state) <b>Emmitsburg, Md.</b>		DATE SIGNED <b>5-30-56</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 1 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>A. H. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. This certificate may be recorded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

JUN 1 1956

RECEIVED

5130

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Montgomery</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Cullen</b>	LENGTH OF STAY (in this place) <b>61 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Silver Spring</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>		STREET ADDRESS (If rural give location) <b>2818 Harris Ave.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Thomas Luther Franklin</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>5 20 1956</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. <del>SINGLE</del> <del>MARRIED</del> <del>WIDOWED</del> <del>DIVORCED</del> (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>6/14/1872</b>
9. AGE last birthday <b>83</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>	
11. BIRTHPLACE (State or foreign country): <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>William Franklin</b>		14. MOTHER'S MAIDEN NAME: <b>Josephine Weitzel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.: <b>None</b>	
17. INFORMANT & ADDRESS: <b>Thomas Luther Franklin</b> <b>2818 Harris Ave., Silver Spring, Md.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Pulmonary tuberculosis</b>		Unknown	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/20/1956</b> , to <b>5/20/1956</b> , that I last saw the deceased alive on <b>5/20/56</b> , 19 <b>56</b> , and that death occurred at <b>1:05 AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		M. D. <b>Cullen, Maryland.</b> DATE SIGNED <b>5/21/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 23, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5/21/56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 22 1956

BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5110 CERTIFICATE OF DEATH

05111

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick-Memorial Hospital</b>		e. STREET ADDRESS <b>128 East Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Hackey-Allen - Virginia McBurge</b>		4. DATE OF DEATH <b>May 9 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1894</b>
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Montgomery Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Fredericks</b>		14. MOTHER'S MAIDEN NAME <b>Lee Ellen McGruder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Grace Hoy Carroll</b> Address <b>128 East Street Fred. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 Apr</b> , 1956, to <b>9 May</b> , 1956, that I last saw the deceased alive on <b>9 May</b> , 1956, and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5-11-56</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Thomas E Stone</b> M.D.			
PHYSICIAN'S NAME (Type) <b>T.E. Stone</b>		<b>4 West 3rd Street Frederick-Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 12-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eberneezzer</b>	22d. LOCATION (City, town, or county) (State) <b>Centerville-Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b> ADDRESS <b>Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>11 May 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	



**BUREAU V. 5**

MAY 14 1956

RECEIVED

5131

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Fred.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point Of Rocks</b>		c. LENGTH OF STAY IN 1b <b>Frederick Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>23 West All Saints St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Earl</b> Last <b>Hamilton</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28-1913</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Barnesville Montgomery Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-6147</b>	
17. INFORMANT <b>Ida Stewart Gwynn</b>		Address <b>23 W. All Saints St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9299</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Accidental Drowning</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6:18 p. m. 5-22 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>May 23-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-25-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		ADDRESS <b>Fred. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>24 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one is necessary, please execute 1. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. Jones		Male		45		May 28, 1956	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Medical History		Family History	
Teacher		High School		Hypertension		None	
Previous Illnesses		Drugs Taken		Alcohol Consumption		Tobacco Use	
None		None		Occasional		Occasional	
Date of Autopsy		Autopsy Performed By		Signature of Examiner		Signature of Coroner	
May 29, 1956		Dr. J. A. Smith		[Signature]		[Signature]	

**BUREAU V. S.**  
MAY 28 1956  
**RECEIVED**

5111

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Mem. Hospital</u>				d. STREET ADDRESS <u>Mt. Olive</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				06X-2			
3. NAME OF DECEASED (Type or print) First <u>Roscoe</u> Middle <u>A.</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-1907</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Upton Henry</u>				14. MOTHER'S MAIDEN NAME <u>Effie Fleming</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Effie Henry, Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>56</u> , to <u>5/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/3</u> , 19 <u>56</u> , and that death occurred at <u>12:15 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Church St. Frederick, Md.</u> DATE SIGNED <u>5/3/56</u>							
ACTUAL SIGNATURE <u>Henry V. Chase M.D.</u>				PHYSICIAN'S NAME (Type) <u>Henry V. Chase M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>5-6-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	
22d. LOCATION (City, town, or county) <u>Carroll Co., Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. M. Watz</u>				ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3 May 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hecker</u>							

MEDICAL CERTIFICATION

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		MAY 7 1956		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		Male		White	
BIRTH DATE		BIRTH PLACE		MANNER OF DEATH	
MAY 12 1891		BALTIMORE, MARYLAND		Natural	
OCCUPATION		EDUCATION		CAUSE OF DEATH	
Retired		High School		Heart Disease	
PREVIOUS ILLNESS		HYGIENE		TREATMENT	
None		Good		Hospital	
DATE OF EXAMINATION		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
MAY 7 1956		J. H. HARRIS		J. H. HARRIS	

BUREAU V. E.

MAY 7 1956

RECEIVED



5112

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05114

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		35	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>		d. STREET ADDRESS <b>20 South Virginia Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Agusta</b> Last <b>Hoffmaster</b>		4. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>I-20-1901</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Town employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brunswick</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Thomas Hoffmaster</b>		14. MOTHER'S MAIDEN NAME <b>Annie Mae Badger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-14-1368</b>	
17. INFORMANT <b>Mrs. Stella M. Hoffmaster, Brunswick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, left middle cerebral artery</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Hypertension, severe</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b> <b>year</b> <b>year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8, 1956</b> , to <b>May 24, 1956</b> , that I last saw the deceased alive on <b>May 24, 1956</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 East Church St. Frederick, Md.</b> DATE SIGNED <b>MARYLAND</b>			
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.		22a. REC'D BY REGISTRAR <b>MAY 29 1956</b>	
PHYSICIAN'S NAME (Type) <b>Robert S. Turner, Jr.</b>		24b. REGISTRAR'S SIGNATURE <b>Ely. G. Beck</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-27-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brethern</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville Wash. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Felt</b>		ADDRESS <b>Brunswick, Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

ALL CASES

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. PLACE OF DEATH [Faint text]</p>		<p>6. CAUSE OF DEATH [Faint text]</p>	
<p>7. PLACE OF BIRTH [Faint text]</p>		<p>8. OCCUPATION [Faint text]</p>		<p>9. MARITAL STATUS [Faint text]</p>	
<p>10. SIGNATURE OF DECEASED [Faint text]</p>		<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF CORONER [Faint text]</p>		<p>14. SIGNATURE OF JURY [Faint text]</p>		<p>15. SIGNATURE OF JUDGE [Faint text]</p>	

BUREAU V. 3

MAY 29 1956

RECEIVED

5132

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Md.</b>				c. LENGTH OF STAY IN 1b <b>25 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Huebener</b> Last <b>Huebener</b>				4. DATE OF DEATH Month <b>May</b> , Day <b>18</b> , Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1876</b>	9. AGE (In years lost birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Moravian Church</b>		11. BIRTHPLACE (State or foreign country) <b>Lititz, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mathias Huebener</b>				14. MOTHER'S MAIDEN NAME <b>Mary S. Lichtenthaeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mary Grimes Huebener-Thurmont, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease, chronic valvular</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Branchopneumonia - 1 day</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>no</b> p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 16</b> , 19 <b>56</b> , to <b>May 18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 17</b> , 19 <b>56</b> , and that death occurred at <b>12:54</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED _____							
ACTUAL SIGNATURE <b>James K. Gray</b> M.D.				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <b>Dr. James K. Gray</b>				Thurmont, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 21 1956</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

Frederick

Baltimore

MARYLAND

Frederick

Thurmont, Md.

22 yrs.

Thurmont, Md.

Husband

Robert

May 1935

April 20, 1935

White

Male

Norvian Church

Minister

Mary S. Henderson

Miss Henderson

Mary S. Henderson-Thurmont, Md.

No

BUREAU V. S.

MAY 21 1935

RECEIVED

Thurmont, Md.

James K. Gray

U.S. Cemetery

Thurmont, Md.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5113**  
**CERTIFICATE OF DEATH**

**05116**

Reg. Dist. No. **131**

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>500 West South Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>STANLEY</b> Last <b>HURD</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Jan 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Hurd</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Harper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5246</b>		17. INFORMANT Address <b>Mrs. Edith Hurd (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <b>56</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>56</b> , to <b>May 22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>56</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rex R. Martin</b>				M.D. <b>35 E. Church St., Frederick, Md.</b> DATE SIGNED <b>5/24/56</b>			
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>24 May 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

131

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15, 1920</i>		5. PLACE OF BIRTH <i>Baltimore, Md</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>May 10, 1966</i>		11. TIME OF DEATH <i>10:30 AM</i>		12. PLACE OF DEATH <i>Home</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
16. SIGNATURE OF CORONER <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JUDGE <i>John Doe</i>	
19. SIGNATURE OF CLERK <i>John Doe</i>		20. SIGNATURE OF REGISTRAR <i>John Doe</i>		21. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
22. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		23. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		26. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		27. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
28. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		29. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		30. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
31. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		32. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		33. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
34. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		35. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		36. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
37. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		38. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		39. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
40. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		41. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		42. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
43. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		44. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		45. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
46. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		47. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		48. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
49. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		50. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		51. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
52. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		53. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		54. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
55. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		56. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		57. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
58. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		59. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		60. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
61. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		62. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		63. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
64. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		65. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		66. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
67. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		68. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		69. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
70. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		71. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		72. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
73. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		74. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		75. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
76. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		77. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		78. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
79. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		80. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		81. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
82. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		83. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		84. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
85. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		86. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		87. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
88. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		89. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		90. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
89. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		90. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		91. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
90. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		91. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		92. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
91. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		92. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		93. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
92. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		93. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		94. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
93. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		94. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		95. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
94. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		95. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		96. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
95. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		96. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		97. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
96. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		97. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		98. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
97. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		98. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		99. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	
98. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		99. SIGNATURE OF ASSISTANT REGISTRAR <i>John Doe</i>		100. SIGNATURE OF ASSISTANT ARCHIVIST <i>John Doe</i>	

BUREAU V. 3

MAY 28 1966

RECEIVED

5133

## CERTIFICATE OF DEATH

Reg. Dist. No.

140

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Adams</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ladiesburg</b>				c. LENGTH OF STAY IN 1b <b>15 Mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>JUNK</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 56</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1880</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>29</b> Hours <b>56</b>		IF UNDER 24 HRS. Months <b>7</b> Days <b>29</b> Hours <b>56</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Honey Grove, Pa.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Junk</b>				14. MOTHER'S MAIDEN NAME <b>Tillie VanSweargin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>209-12-8310</b>			
17. INFORMANT <b>Mrs Ruth Junk, 316 E. Middle St. Gettysburg Pa.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>?</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 2, 1956</b> , to <b>May 29, 1956</b> , that I last saw the deceased alive on <b>May 29, 1956</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M. Frank Burch</b> M.D. <b>Thurmond</b> <b>5/30/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>6/1/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gettysburg, Adams Co. Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emmett Bender</b>				24a. REC'D BY REGISTRAR <b>May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>L B Powell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 5

JUN 5 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5123

CERTIFICATE OF DEATH

05118  
141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 415 Brunswick Street		d. STREET ADDRESS 415 Brunswick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Catharine Kaetzel		4. DATE OF DEATH May 19 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles William Fry		14. MOTHER'S MAIDEN NAME Mary Margaret Goodman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address Mr. John W. Kaetzel Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 794X IMMEDIATE CAUSE (a) DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19 49 to 5-19-1956 that I last saw the deceased alive on 5-19-1956, and that death occurred at 7:55 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 5-21-56	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-21-1956	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Tate		24a. REC'D BY REGISTRAR DATE 5/23/56	
24b. REGISTRAR'S SIGNATURE Eugene Burke			

CERTIFICATE OF DEATH

8125

Date of Birth		Date of Death		Place of Birth		Place of Death	
1911		1956		Maryland		Maryland	
Sex		Race		Marital Status		Occupation	
Male		White		Married		Farmer	
Age		Cause of Death		Date of Burial		Place of Burial	
45		Heart Disease		1956		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 8

MAY 23 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05119

5134

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Nr. Frederick</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rt. 4 - Frederick,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>OTIS</b> Last <b>KING</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1872</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James H. King</b>				14. MOTHER'S MAIDEN NAME <b>Mary Essex</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-32-5383</b>		17. INFORMANT Address <b>Mr. Carlton T. King - Rt. 4 - Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1950</b> , to <b>May 2, 1956</b> , that I last saw the deceased alive on <b>May 1, 1956</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Thomas</b> M.D.				ADDRESS (Street, city or town, state) <b>Frederick Md</b> DATE SIGNED <b>May 4-56</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Sr.</b>				Professional Bldg.-Frederick-Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline + Son - Frederick - Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 4 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Eligible G. Heck</b>	

3

5135

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BRADDOCK</u>				c. LENGTH OF STAY IN 1b <u>4 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK R.S.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SILAS DANIEL KUHN SR.</u>				4. DATE OF DEATH <u>MAY - 6 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH - 6 - 1901</u>	
9. AGE (In years last birthday) <u>55-2-0</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE ENGINEER STATE ROAD COMMISSION</u>		11. BIRTHPLACE (State or foreign country) <u>PONDSVILLE WASH. CO. IND. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAMUEL KUHN</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN SENSEN BAUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. BEULAH KUHN FREDERICK MD. R.S</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of bowel with metastasis</u> DUE TO (c) <u>3 days</u> 3 yrs.				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>55</u> , to <u>5/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>56</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth C. Henson</u> M.D.				ADDRESS (Street, city or town, state) <u>Middletown</u> DATE SIGNED <u>5/8/56</u>			
PHYSICIAN'S NAME (Type) <u>Kenneth C. Henson MD. Middletown</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY - 9 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 11 May 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1

may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 14 1956

RECEIVED

05121

5114

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nellie</b> First <b>Blanche</b> Middle <b>Long</b> Last		4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/83</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laundry worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ernst Rautzahn</b>		14. MOTHER'S M maiden name <b>Allice Busch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>219-20-2965</b>	
17. INFORMANT <b>Leslie H. Long</b> Address <b>Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> DUE TO <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO <b>6 mo.</b> (c) <b>diabetes mellitus</b> DUE TO <b>10 yrs +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/25</b> , 19 <b>56</b> , to <b>5/26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/25/56</b> , 19 <b>56</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.		ADDRESS (Street, city or town, state) <b>4 E Church St</b> DATE SIGNED <b>5/26/56</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase Frederick Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/28/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co.</b> ADDRESS <b>Middletown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>29 May 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Elyzabeth G. Heck</b>	



13

BUREAU T. S.

MAY 31 1956

RECEIVED

5115

CERTIFICATE OF DEATH

05122

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>231 East Church Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>EADER</b> Last <b>MacMUNN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 Oct 1872</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Mantz Eader</b>				14. MOTHER'S MAIDEN NAME <b>Sidney Ann Bruchey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Bessie M. Shinnick, Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>794x Senility</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>June 1, 1955</b> to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>7 A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E. Church St., Frederick, Md.</b> DATE SIGNED <b>5/11/56</b>							
ACTUAL SIGNATURE <b>Rex R. Martin</b> M.D.				PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>14 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>11 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Hesk</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 27 10.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05123

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg RD #1</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg RD #1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>John Michael Manning</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>5</u> Year <u>1956</u>				<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 3-1885</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u> <b>13. FATHER'S NAME</b> <u>Jacob Manning</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Pa.</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Jane Smith</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>213-18-0723</u>		<b>17. INFORMANT</b> <u>Mary Ellen Manning</u> Address <u>Emmitsburg RD #1</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>B. O. Thomas</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>B. O. Thomas</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>May 5-1956</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 8-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel Cemetery</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>S. L. Allison</u> <b>ADDRESS</b> <u>Emmitsburg, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>May 8 1956</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>H. H. Kriches</u>		<b>24c. LOCATION (City, town, or county)</b> <u>Washington Co. Md.</u> (State)			

TO DETERMINE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____			
MANNER OF DEATH _____			
SIGNATURE OF MEDICAL EXAMINER _____			
DATE OF SIGNATURE _____			
SIGNATURE OF WITNESS _____			
DATE OF SIGNATURE _____			
SIGNATURE OF CORONER _____			
DATE OF SIGNATURE _____			

BUREAU V. 41

MAY 8 1956



5137

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Dale</b>				c. LENGTH OF STAY IN 1b <b>25 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Thomas</b> Last <b>Marshall</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1873</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rented farms</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Jane R. Bowers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-6876</b>		17. INFORMANT <b>Jesse R. Marshall -- Thurmont, Md. R#1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease, Myocardial ischemia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Coronary Type</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20, 1956</b> , to <b>May 27, 1956</b> , that I last saw the deceased alive on <b>May 26, 1956</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>May 28-1956</b>							
ACTUAL SIGNATURE <b>James T. Gray</b>				M.D. <b>Thurmont - Md.</b>			
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>				<b>Thurmont, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/30/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewistown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Gray</b>				ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>1 June 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

Name of Deceased		Sex		Age	
John A. Smith		Male		45	
Date of Death		Place of Death		Cause of Death	
June 1, 1956		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JUN 4 1956

RECEIVED

100-100000-100000

## 5138 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Montgomery</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>	LENGTH OF STAY (in this place) <b>324 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hosp.</b>		STREET ADDRESS (If rural give location) <b>4905 Hampden Lane</b>	
3. NAME OF DECEASED: (First) <b>Laura</b> (Middle) (Last) <b>McMahon</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>5 3 19 56</b>	
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, <del>WIDOWED</del> <b>Widow</b>	8. DATE OF BIRTH: <b>7/9/1879</b>
9. AGE last birthday <b>76</b> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Nurse</b>	
11. BIRTHPLACE (State or foreign country): <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>S. S. Bridgers</b>		14. MOTHER'S MAIDEN NAME: <b>Margaret Sheppard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Laura McMahon</b> <b>4905 Hampden Lane, Bethesda, Md.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Pulmonary tuberculosis</b>			<b>1 yr.</b>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Diabetes Mellitus</b>			<b>11 yrs.</b>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/14</b> , 19 <b>55</b> to <b>5/31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/31</b> , 19 <b>56</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		ADDRESS <b>Cullen, Maryland</b> DATE SIGNED <b>5/3/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 7, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Blandford@Dinwiddie Co.Va.</b>		LOCATION (City, town, or county) (State) <b>Petersburg, Va.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5/3/56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAY 2 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05126

5139

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>West Va.</u>		COUNTY <u>Jefferson</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Brunswick (Rural)</u>		<u>1 year</u>		TOWN <u>Bakerton (Rural)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>90 Rosemont</u>				<u>Old Furnace Road</u>			
<b>3. NAME OF DECEASED</b> (Type of Print)				<b>4. DATE OF DEATH</b>			
(First) <u>GARLAND</u>		(Middle) <u>HIRST</u>		(Last) <u>MOHLER</u>		(Month) <u>May</u> (Day) <u>5</u> (Year) <u>56</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan. 21, 1879</u>	<u>77</u> yrs.	Months <u>3</u>	Days <u>14</u>	Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>Gen. Farm</u>		<u>Jefferson County, W.Va.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>George White Mohler</u>				<u>Henrietta Harwood</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>Mr. Harwood Watson</u> <u>Rosemont, Brunswick, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				<u>Antecedent Cause(s) DUE TO</u>		<u>None</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>None</u>		<u>None</u>	
(C) <u>None</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 21, 1879</u> <b>to</b> <u>May 5, 1956</u> <b>that I last saw the deceased</b> <u>alive on</u> <u>4/10</u> <b>and that death occurred at</b> <u>11:00 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>DATE SIGNED</b> <u>May 5, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial-Removal</u>				<u>5/8/56</u>		<u>Elmwood Cemetery</u> <u>Shepherdstown, West Va.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>5-9-56</u>		<u>Eugenia H. Burkett</u>		<u>Ronald Zickler</u>		<u>Harpers Ferry, West Va.</u>	



MAY 11 1956

RECEIVED  
MAY 11 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5140 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05127

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Fred.</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Of Rocks</u>		c. LENGTH OF STAY IN TB  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  				d. STREET ADDRESS <u>118 Ice Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Robert</u> <u>Monroe</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May</u> <u>22</u> <u>19 56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER-MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Oct 29, 1894</u>		<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hard Carrier</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>*****</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Kempton - Fred. Co. Md.</u>			
<b>13. FATHER'S NAME</b> <u>Henry Monroe</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Brown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-14-9121</u>		<b>17. INFORMANT</b> Address <u>James Monroe</u> <u>Fountain Mills Fred. Co.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>929.9</u>  <b>DUE TO</b>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b> <u>Accidental Drowning</u>  <b>DUE TO</b>  <b>(c)</b> _____       </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>6:18</u> p.m. <u>MAY 22 1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>B.O. Thomas</u> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>B.O. Thomas</u>				<b>DATE SIGNED</b> <u>May 23-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5-25-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fountain Mills</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Frederick Co. Md.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Hicks III Frederick, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>May 19 1956</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Elizabeth S. Hersh</u>				 			

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

MAY 28 1956

RECEIVED

Handwritten signature and date: *Handwritten signature* 5/28/56

## 5141 CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>		LENGTH OF STAY (If in this place) <b>463 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Westernport</b> <i>01X-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hosp.</b>				STREET ADDRESS (If rural give location) <b>Rt. 1</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Mary Eva Morris</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>5 11 19 56</b>			
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>4/20/1900</b>	9. AGE last birthday <b>56</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housework</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>housewife</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Edward Bradley</b>				14. MOTHER'S MAIDEN NAME: <b>Joann Linkswiller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>Mary Eva Morris Rt. 1, Westernport, Maryland.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Chronic pulmonary abscess</b>						<b>5 years</b>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2/3/...</b> , 19 <b>55</b> to <b>5/11/...</b> , 19 <b>56</b> that I last saw the deceased alive on <b>5/11/...</b> , 19 <b>56</b> and that death occurred <b>12:35</b> M, from the causes and on the date stated above. SIGNATURE <i>[Signature]</i> ADDRESS <b>Cullen, Maryland.</b> DATE SIGNED <b>5/11/56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 14, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Philos</b>		LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5/11/56</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR <b>Ellsworth S. Boal, Westernport, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1956

BUREAU V. S.



TO DEPENDENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05129  
181  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson-Rural-RD#1</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson-Rural-RD#1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Dickerson-Rural-RD#1</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>MOXLEY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> , Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <b>MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1872</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Moxley</b>				14. MOTHER'S MAIDEN NAME <b>Annie Riley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles W. Moxley, Dickerson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas Sr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, lawn, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>31 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

DATE SIGNED

5/31/1956

RECEIVED

5143

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. <del>CITY</del> OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ERNEST</b> Last <b>MYER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1876</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Sgt. Maj.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. M. C.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George E. Myer</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Donnelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>WWI</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Rolph M. Culler, Jefferson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Block</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Advanced Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>54-10</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>2/7</b> , 19 <b>56</b> to <b>5/14</b> , 19 <b>56</b> that I last saw the deceased alive on <b>5/13</b> , 19 <b>56</b> , and that death occurred at <b>3:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b> DATE SIGNED <b>5/15/1956</b>							
ACTUAL SIGNATURE <b>Dr. A. T. Brice</b> M.D.				PHYSICIAN'S NAME (Type) <b>Jefferson, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 16, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>15 May 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

MAY 17 1955

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05131

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span> b. <del>CITY OR TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <b>Walkersville-RD#1</b> c. LENGTH OF STAY IN lb <b>4 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hoffman-Seacrist Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. <del>CITY OR TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <b>Walkersville -Rural-R.D.#1</b> d. STREET ADDRESS <b>Hoffman-Seacrist Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WALTER</b> Middle <b>RAY</b> Last <b>NEWTON</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>24</b> Year <b>1956</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>March 7, 1890</b> <b>9. AGE</b> (In years last birthday) <b>66 yrs.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Richard T. Newton</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary F. Kidwell</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>188-05-6030</b>		<b>17. INFORMANT</b> <b>Mrs. Lonie W. Newton, Walkersville R.D.#1, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>420.1</b> <b>Coronary occlusion</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 minutes</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour <b>a. m.</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <b>Noturol causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>B. O. Thomas</b> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>B. O. Thomas Sr.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>May 24, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>May 26, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lakeview Cemetery</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Hamilton</b> <b>(State)</b> <b>Virginia</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					
<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Elizabeth G. Heck</b>		<b>DATE</b> <b>25 May 1956</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

MAY 23 1956

BUREAU V. 2

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5145

## CERTIFICATE OF DEATH

05132

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Walkersville</u>		<u>3 yrs</u>		TOWN <u>Rural, Walkersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SUSIE</u> (Middle) <u>ELIZABETH</u> (Last) <u>MUSBAUM</u>				(Month) <u>May</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>F</u>	<u>W</u>	<u>married</u>	<u>April 17, 1877</u>	<u>79</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Casper Lochner</u>				<u>Annie Elizabeth Frushman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mrs John Barnes, Walkersville</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis + myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic CVD</u>						<u>5 minutes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>10 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>30 May, 1956</u> , to <u>30 May, 1956</u> , that I last saw the deceased alive on <u>May 19, 1956</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>James S. Stone, Jr.</u>		<u>6/2/56</u>		<u>Chapel</u>		<u>Libertytown, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>Elizabeth S. Heck</u>		<u>GC Barton, Walkersville, Md</u>			
DATE <u>1 June 1956</u>							

CERTIFICATE OF DEATH

131

1. DEATH CERTIFICATE NUMBER OR REGISTRATION

11

MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE

2. PLACE OF DEATH

11

3. SEX  
4. AGE  
5. OCCUPATION  
6. CAUSE OF DEATH  
7. DATE OF DEATH  
8. TIME OF DEATH  
9. PLACE OF BIRTH  
10. PLACE OF DEATH  
11. PLACE OF INTERMENT  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF DEATH CERTIFICATE  
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BUREAU V. S.

JUN 27 1956

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1 June 1956  
Ephraim & Hester

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5146  
CERTIFICATE OF DEATH

05133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>				c. LENGTH OF STAY IN 1b <b>92 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emmitsburg, R D.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>S. E.</b> Last <b>Ohler</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1862</b>	
9. AGE (In years last birthday) <b>94 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Adams Co., Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Baker</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth J. Flohr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Russell B Ohler</b> Address <b>Emmitsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5</b> , 1956, to <b>May 5</b> , 1956, that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Emmitsburg, Md.</b> <b>May 6, 1956</b>							
ACTUAL SIGNATURE <b>Charles R. Williams</b> M.D. <b>Emmitsburg, Md.</b>				PHYSICIAN'S NAME (Type) <b>Charles R. Williams M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b> <b>S. L. Allison</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

MAY 8 1956

RECEIVED



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5147

## CERTIFICATE OF DEATH

Reg. Dist. No.

05134

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middletown</i>				c. LENGTH OF STAY IN 1b <i>25 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>F.</i> Last <i>Palmer</i>				4. DATE OF DEATH Month <i>5</i> Day <i>6</i> Year <i>1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-6-1883</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Building Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>							
13. FATHER'S NAME <i>Carlton Palmer</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Paffenberger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>214-14-6556</i>		17. INFORMANT <i>Ms. Nettie Palmer, Middletown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hodgkins Disease</i> <i>201X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>? 7 mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>Feb 10, 1956</i> , to <i>May 6, 1956</i> , that I last saw the deceased alive on <i>May 3, 1956</i> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. Elmer Harp</i> M.D.				ADDRESS (Street, city or town, state) <i>Middletown</i> DATE SIGNED <i>5-7-56</i>			
PHYSICIAN'S NAME (Type) <i>J. Elmer Harp</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-8-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Middletown, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co.</i> ADDRESS <i>Middletown, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>9 May 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 10 1956

RECEIVED

5148

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>	LENGTH OF STAY (in this place) <b>347 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	<b>3101.4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>		STREET ADDRESS (If rural give location) <b>2211 Winterling County</b>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <b>Chester</b>	(Middle)	(Last) <b>Rakowski</b>	OF DEATH: <b>5 26 19 56</b>
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, <del>WIDOWED</del> , <del>DIVORCED</del> (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>1/12/1908</b>
9. AGE last birthday <b>48</b> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marble cutter</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Marble cutter</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Adolf Rakowski</b>		14. MOTHER'S MAIDEN NAME: <b>Mary Rutkowski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>212-10-1020</b>	
17. INFORMANT & ADDRESS: <b>Chester Rakowski</b> <b>2211 Winterling Court, Baltimore, Maryland.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma of larynx</b>			<b>14 mos.</b>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Pulmonary tuberculosis</b>			<b>Unknown</b>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>6/14/55</b> , 19....., to <b>5/26/</b> , 19 <b>56</b> ., that I last saw the deceased alive on <b>5/26/56</b> , 19....., and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
SIGNATURE <i>[Signature]</i>		M. D. <b>Cullen, Maryland.</b> DATE SIGNED <b>5/28/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 30, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		LOCATION (City, town, or county) (State) <b>Dundalk, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5/28/56</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR <b>John M. Weber, 401 S. Chester, St. Balto. Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 29 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05136

5149

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Braddock Heights</b>		LENGTH OF STAY (in this place) <b>1 yr</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vindobona Braddock Heights</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mr. George</b> (First) <b>Rea</b> (Middle) <b>Rea</b> (Last)				<b>4. DATE OF DEATH</b> (Month) <b>May</b> (Day) <b>20</b> (Year) <b>1956</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>1/29/84</b>	<b>9. AGE last birthday</b> <b>72</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charley Rea</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Richard</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes Spanish Amer.</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Wife - Braddock Heights</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>241X</b> IMMEDIATE CAUSE (A) <b>Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cor Pulmonale</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Emphysema + Bronchial Asthma</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arteriosclerosis</b>							
<b>19a. DATE OF OPERATION</b> <b>None</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Sept 10, 1955</b> , to <b>May 20, 1956</b> , that I last saw the deceased alive on <b>May 19, 1956</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>A. A. Pearre</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Frederick Md.</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>5/22/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Frederick, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>22 May 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Elizabeth S. Hersh</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Roy W. Barber</b> <b>Laytonville Md</b>			



# CERTIFICATE OF DEATH

131

1. UNDER SIGNATURE (NUMBER OF RECORDS)

THE Maryland State Department of Health

Frederick

Frederick  
Frederick  
Frederick

1/20/54

White

U A  
Maryland State Department of Health

Charles Lee

Frederick

MEDICAL INVESTIGATION



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Baltimore & Haver

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

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131

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Urbana---Rural</b>				c. LENGTH OF STAY IN 1b <b>5 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>Layman</b> Last <b>REED</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/1/1902</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter---General building</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Russell C. Reed</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-46-8193</b>		17. INFORMANT <b>Mrs Cecil Reed, Ijamesville-R.F.D. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute mastoiditis</b> 393.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>5-2</b> , 19 <b>56</b> , to <b>5-11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-11</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E Stone</b> <b>4 W 3rd St</b> <b>5-11-56</b>							
ACTUAL SIGNATURE				M.D.			
PHYSICIAN'S NAME (Type) <b>Thomas E. Stone</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 14-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Helton, Barnsville</b> <i>per wife</i>				ADDRESS <b>Md</b>		24a. REC'D BY REGISTRAR DATE <b>May 12, '56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b> <i>Ely S. Helton</i>			

MEDICAL CERTIFICATION

TO HOSPITAL: After death: Page 4  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MAYNARD STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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MAY 15 1956  
BUREAU V. S.

MAY 15 1956

5150

## CERTIFICATE OF DEATH

Reg. Dist. No.

13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Amey K. Remsberg</b>		4. DATE OF DEATH Month <b>5</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/1865</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Horatio B. Kefauver</b>		14. MOTHER'S MAIDEN NAME <b>Mary Glessner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Arthur R. Remsberg</b>		Address <b>Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>1</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1956</b> , to <b>May 9, 1956</b> , that I last saw the deceased alive on <b>May 9, 1956</b> , and that death occurred at <b>4:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elmer Harp</b> M.D.		DATE SIGNED <b>Middletown Md. 5-9-56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>		<b>Middletown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS <b>Middletown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

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BUREAU V. S.

MAY 14 1956

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5151 CERTIFICATE OF DEATH

05139

Reg. Dist. No. 147

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Mt. Airy</b>				c. LENGTH OF STAY IN 1b <b>11 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Black Ankle Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ELMER</b> Last <b>RUBY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-3-1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William Ruby</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Horton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W. I</b>	
16. SOCIAL SECURITY NO. <b>214-16-0299</b>		17. INFORMANT <b>Virgie Ruby,</b> Address <b>Mt. Airy, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 day</b> <b>Few years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>June, 1952</b> , to <b>May, 1956</b> , that I last saw the deceased alive on <b>May 2, 1956</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. B. Culwell</b> M.D.				ADDRESS (Street, city or town, state) <b>Mt. Airy, Md.</b> DATE SIGNED <b>May 3, 1956</b>			
PHYSICIAN'S NAME (Type) <b>W. B. CULWELL</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-7-1956</b>		22c. NAME OF CEMETERY <b>Locust Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. M. Wertz</b> ADDRESS <b>Winfield, Md.</b>				24a. REC'D. BY REGISTRAR <b>May 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blair A. Ruckler</b>	

BUREAU V. 52

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CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN RURAL</u>				c. LENGTH OF STAY IN 1b <u>3 MO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>DOUGLAS</u> Last <u>SCHELL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 13 - 1954</u>		9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>EUGENE SCHELL</u>				14. MOTHER'S MAIDEN NAME <u>NORMA BOWERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>RURAL</u> <u>EUGENE SCHELL LIBERTYTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Broncho Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1956</u> to <u>May 12, 1956</u> that I last saw the deceased alive on <u>May 12, 1956</u> and that death occurred at <u>54 M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER MD.</u>				DATE SIGNED <u>May 13</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 15 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>LINDEN HILLS PARA FREDERICK</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Bartzler &amp; Sons Libertytown, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 17 May 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

181

BUREAU V. S.

MAY 18 1956

RECEIVED

11/11/56

5153

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>STEINER</b> Middle <b>GARRY</b> Last <b>SHANKLE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1887</b>		9. AGE (In years last birthday) yrs. <b>69</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin L. Shankle</b>				14. MOTHER'S MAIDEN NAME <b>Julia Angleberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs. Hester B. Shankle, Buckeystown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia terminal</b> <b>493x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma rectum</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20th, 1955</b> , to <b>May, 30th, 1956</b> that I last saw the deceased alive on <b>May, 26th, 1956</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church St. Frederick, Md.</b> DATE SIGNED <b>5/31/1956</b>							
ACTUAL SIGNATURE <b>J. M. Baxter</b>				M.D. <b>East Church St. Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. M. Baxter</b>				East Church St., Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mounr Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>31 May 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1956

1956

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JUDGE [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF [Faint text] [Faint text]	

BUREAU V. 3

JUN 1 1956

RECEIVED

5117

## CERTIFICATE OF DEATH

05142

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick MEM. Hospital</u>				d. STREET ADDRESS <u>_____</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Nettie B. SIER</u>				4. DATE OF DEATH Month Day Year <u>May 30 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nicholas A. PERKINS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MARY BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Wilmer D. SIER - Ijamsville - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>56</u> , to <u>May 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>56</u> , and that death occurred at <u>5<sup>15</sup></u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>New Market - Md.</u> DATE SIGNED <u>5-30-56</u>							
ACTUAL SIGNATURE <u>Ralph L. Michels</u> M.D.				PHYSICIAN'S NAME (Type) <u>Ralph L. Michels</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Clum - Son - Frederick - Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 31 May 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb</u>	

TO HOSPITAL: After death: Page 4  
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

1. PLACE OF DEATH		2. SEX	
3. AGE		4. OCCUPATION	
5. MARITAL STATUS		6. RACE	
7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN	
15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

BUREAU V. S.

JUN 1 1956

RECEIVED

5-31-56

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05143

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>15 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Walkersville</u> X d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charlotte Rebecca</u> First Middle Last <b>4. DATE OF DEATH</b> <u>May 30</u> Month Day Year <u>1956</u>			<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9/29/14</u> <b>9. AGE</b> (In years last birthday) <u>13</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Grade School</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Clarence L. Smith</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Itha M. Moser</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Clarence L. Smith</u> Address <u>Walkersville</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 1/2 hours</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>Clothes caught fire from electrical plug</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5/20 1956</u> Hour a. m. <u>2</u> p. m. <b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Walkersville</u> (County) <u>Frederick</u> (State) <u>Md</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>B. D. Thomas</u> <b>EXAMINER'S NAME (Type)</b> <u>B. D. Thomas</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>May 31-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>6/2/56</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rocky Hill</u> <b>22d. LOCATION (City, town, or county)</b> <u>Frederick Co.</u> (State) <u>Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Elizabeth B. Heck</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Elizabeth B. Heck</u> <b>DATE</b> <u>2 June 1956</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Powell &amp; Hartzler, Woodboro, Md</u> <b>ADDRESS</b> _____							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 5 1956

RECEIVED

*Handwritten signature and notes at the bottom left of the page.*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5154

## CERTIFICATE OF DEATH

05144  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindabona Convalescent Home</b>				d. STREET ADDRESS <b>21 East Church Street</b>			
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>WOLFE</b> Last <b>SNYDER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1889</b>	9. AGE (In years last birthday) yn. <b>66</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Eli Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Frances Page</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Maxine W. Snyder,</b> Address <b>21 East Church Street, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr Myocarditis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7</b> , 19 <b>48</b> , to <b>May 12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>56</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 East Second St., Frederick, Md.</b> DATE SIGNED <b>5/14/1956</b> ACTUAL SIGNATURE <b>H. L. Fahrney</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. H. L. Fahrney</b> <b>17 East Second St., Frederick, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 14 May 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **13**

05145

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> c. LENGTH OF STAY IN b <u>10 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW MARKET</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Olive</u> First <u>W</u> Middle <u>Sponseller</u> Last		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>10</u> Year <u>1956</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7/20/86</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>69</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>GEORGE E. WOLFE</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>GEORGANNA CLAY</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>GEORGE W. SPONSELLER</u> Address <u>NEW MARKET</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis / Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis with Hemiplegia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>10 yrs. +</u>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that, I attended the deceased from</b> <u>3/1</u> , 19 <u>56</u> , to <u>5/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/9/56</u> , 19 <u>56</u> , and that death occurred at <u>1:24</u> A. M., from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Henry V. Chase</u> M.D. <u>4 E. Church St</u> ADDRESS (Street, city or town, state) <u>Frederick Md</u> DATE SIGNED <u>5/11/56</u>			<b>PHYSICIAN'S NAME (Type)</b> <u>Henry V. Chase</u>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>MAY 12-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>NEW MARKET CEM</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>NEW MARKET MD</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. E. Falconer</u> ADDRESS <u>New Market Md</u>			<b>24a. REC'D BY REGISTRAR</b> <u>Elizabeth G. Heck</u>		<b>24b. REGISTRAR'S SIGNATURE</b>		

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		MARRIED		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT	

BUREAU V. S.

MAY 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5120

## CERTIFICATE OF DEATH

05146

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Wilson</u> Last <u>Spurrier</u>				4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3-1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u> Hours <u>15</u> Min. <u>2</u>		IF UNDER 24 HRS. Months <u>8</u> Days <u>22</u> Hours <u>15</u> Min. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, general store merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Spurrier</u>				14. MOTHER'S MAIDEN NAME <u>Martha Biggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>			
17. INFORMANT <u>Mrs Howard Spurrier, Poolesville, Md</u>				Address <u>(If yes, give war or dates of service)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Occlusion of left common Iliac</u> DUE TO <u>Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>10yrst</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Bronchopneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>5/22</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/20</u> , 19 <u>56</u> , to <u>5/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>56</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>4 E. Church St</u>							
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Poolesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Wilson, Poolesville</u>				ADDRESS <u>md</u>			
24a. REC'D BY REGISTRAR <u>Charles E. Egan</u>				24b. REGISTRAR'S SIGNATURE <u>Chas. E. Egan</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10-11-1964

1162224

10-10-01

1. 1. The first part of the document is a letter from the author to the reader.

MAY 24 1956

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1522

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5155

## CERTIFICATE OF DEATH

### 05147

### Reg. Dist. No.

### 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#1</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mount Pleasant</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VERNON</b> Middle <b>AUGUSTUS</b> Last <b>STEVENS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 April 1892</b>	
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min. <b>56</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George A. Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Wagner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Mary Bartlett Stevens</b>		Address <b>RD#1, Frederick, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/11</b> , to <b>5/11</b> , 19 <b>56</b> ; that I last saw the deceased alive on <b>5/11</b> , 19 <b>56</b> , and that death occurred at <b>8:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James B. Thomas</b> M.D.				ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James B. Thomas, M. D.</b>				DATE SIGNED <b>5/12/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>15 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>14 May 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>			

CERTIFICATE OF DEATH

0153

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1920		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		SUICIDE		GUNSHOT WOUND		AT HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH	
MAY 15 1956		10:00 PM		AT HOME		BALTIMORE		MARYLAND		UNITED STATES		MAY 15 1956		10:00 PM	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH	
MAY 15 1956		10:00 PM		AT HOME		BALTIMORE		MARYLAND		UNITED STATES		MAY 15 1956		10:00 PM	

RECEIVED  
MAY 15 1956  
BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5121

## CERTIFICATE OF DEATH

Reg. Dist. No. 05148

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>219 West Patrick St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JANET</u> Middle <u>LEE</u> Last <u>Stockman</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 20, 1956</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>CHESTER EUGENE Stockman</u>				14. MOTHER'S MAIDEN NAME <u>GAIL VIRGINIA Miss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother Mrs. Gail Stockman</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> <u>Fetal atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/20</u> , 19 <u>56</u> , to <u>5/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James B. Thomas</u>				ADDRESS (Street, city or town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>5/21/56</u>	
PHYSICIAN'S NAME (Type) <u>James B. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frederick mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Linden Hills - Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline Son - Frederick - Md.</u>				ADDRESS <u>Frederick - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>21 May 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 23 1956

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5122

CERTIFICATE OF DEATH

05149  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>35 Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				d. STREET ADDRESS <b>24 Taney Apartments</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SUSANNAH</b> Middle <b>VIRTS</b> Last <b>VIRTS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 July 1882</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>7</b> Hours <b>13</b> Min. <b>13</b>		IF UNDER 24 HRS. Months <b>13</b> Days <b>7</b> Hours <b>13</b> Min. <b>13</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John T. Vickers</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Wade</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>William E. Virts (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> 794x DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 18, 1956</b> to <b>May 19, 1956</b> , that I last saw the deceased alive on <b>May 18, 1956</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rex R. Martin</b> M.D.				ADDRESS (Street, city or town, state) <b>35 E. Church St., Frederick, Md.</b> DATE SIGNED <b>5/21/56</b>			
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>23 May 1956</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Leesburg, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>22 May 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural		Home		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL	
May 15, 1956		10:30 AM		Home		BALTIMORE		BALTIMORE		BALTIMORE		May 18, 1956		1:00 PM		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED

MAY 23 1956

BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5156

## CERTIFICATE OF DEATH

05150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Md. Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Thurmont, Md. Rural</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Merhl</b> Last <b>Weller</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1895</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WM Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Weller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War I 214-14-6804</b>		17. INFORMANT <b>Mary Floretta Weller-Thurmont, Md. RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>May 21, 1956</b> , to <b>May 21, 1956</b> , that I last saw the deceased alive on <b>May 3, 1956</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>5/31/56</b>							
ACTUAL SIGNATURE <b>M. Franklin Birely</b> M.D.				DATE SIGNED <b>5/31/56</b>			
PHYSICIAN'S NAME (Type) <b>M. Franklin Birely</b>				<b>Thurmont, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				24a. REC'D BY REGISTRAR DATE <b>5/23/56</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Decedent's Name THOMPSON, MARY ELLEN		Date of Birth NOV. 6, 1925	
Sex Female		Race White	
Usual Residence Baltimore, Md.		Date of Death MAY 23, 1956	
Cause of Death Unknown		Place of Death Baltimore, Md.	
Physician GEORGE W. WELLS		Hospital None	
Burial Place None		Date of Burial None	
Signature of Physician GEORGE W. WELLS		Signature of Registrar None	

BUREAU V. S.

MAY 23 1956

RECEIVED

5157

## CERTIFICATE OF DEATH

Reg. Dist. No. 139.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Somerset</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>	LENGTH OF STAY (in this place) <b>3427 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Westover,</b> <b>19X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hosp.</b>		STREET ADDRESS (If rural give location) <b>✓</b>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <b>Maude</b>	(Middle) <b>E.</b>	(Last) <b>Young.</b>	
DECEASED: (Type or Print)		OF DEATH: <b>5</b> <b>12</b> <b>19 56</b>	
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W.</b>	7. SINGLE, MARRIED, OR SEPARATED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH: <b>1/15/1902</b>
9. AGE last birthday <b>54</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Nursing</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Nurse</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Thomas H. Young</b>		14. MOTHER'S MAIDEN NAME: <b>Rose Wingate</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT & ADDRESS: <b>Maude E. Young, Westover, Maryland.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Pulmonary tuberculosis</b>		<b>34 years</b>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12/24</b> , <b>1946</b> , to <b>5/12/</b> , <b>1956</b> , that I last saw the deceased alive on <b>5/12/</b> , <b>1956</b> , and that death occurred at <b>10:15 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		M.D. <b>Cullen, Maryland.</b> <b>5/14/56</b>	
23. BURIAL, CREMATION, REMOVAL, OR OTHER		DATE THEREOF <b>5/15/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Bethany M.P. Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5/14/56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>Dennis &amp; Watson,</b>		ADDRESS <b>Pocomoke City, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

MAY 15 1956

RECEIVED